Physician Attestation of Consumer Capacity

The following client is interested in participating in Consumer Directed Attendant Support Services (CDASS). The client will select, train, and direct attendants to provide personal care, homemaker, or health maintenance (skilled) care. To quality for CDASS, the client's primary care physician shall either attest to the client's capability to direct care with sound judgment or recommend the client utilize an authorized representative. NOTE: Sections of the Nurse Practice Act and Nurse Aide legislation do not apply to CDASS (25.5-6-1101 C.R.S.)

Section I: Client Information Section													
Client Medicaid Number:													
Last Name:				First Name:				Middle Initial:					
Address:				City:				State:			Zip:		
Date of Birth:			Telephone:					Male ☐			Female ☐		

Section II: Medical Information	
The following questions address the stability of the client's medical condition. Only those clients whose medical conditions are considered stable are eligible to participate in the CDASS benefit. Stable health is defined as a medically predictable progression or variation of disability or illness.	
Is the client's health condition stable, as defined above?	Yes ☐ No ☐
Answering "NO" to any of the following questions will require the client to use an authorized representative. It does not preclude the client from participating in CDASS.	
Does this client have the ability to develop and maintain a budget and establish attendant wages and schedules?	Yes ☐ No ☐
Does this client have the ability to understand and monitor conditions of basic health, and recognize how, when, and where to seek appropriate medical assistance (for example: if the client has a respiratory condition and develops shortness of breath would he or she know who to contact)?	Yes ☐ No ☐
Does this client have the ability to direct care including the ability to train attendants on the skilled/unskilled procedure or services needed (for example: training attendants on lifting and transferring needs or how to provide respiratory care)?	Yes ☐ No ☐
Does this client have the ability to make informed decisions about interviewing, selecting, disciplining, dismissing, and otherwise managing attendants?	Yes ☐ No ☐

Section III: Medical Provider							
Attesting Physician Name:				License #			
Address:				City:			
State:		Zip:		Phone:			
Name of Person Completing Form:				Date			
Signature of Attesting Physician:							
Medical Provider Comments: (optional)							